**CENTERS FOR MEDICARE & MEDICAID SERVICES**
**SPECIAL TERMS AND CONDITIONS (STCs)**

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| **NUMBER:** | 21-W-00017-5 |
| **TITLE:** | Michigan Adults Benefits Waiver |
| **AWARDEE:** | Department of Community Health |

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## I. PREFACE

The following are Special Terms and Conditions for the Michigan Adults Benefit Waiver, a Health Insurance Flexibility and Accountability (HIFA) Section 1115 demonstration. The Special Terms and Conditions have been arranged into the following subject areas: General Program Conditions, General Reporting Requirements, Legislation, Eligibility and Enrollment, Benefits, Cost Sharing, Program Design, Operational Protocol, Monitoring and an attachment discussing General Financial Requirements under Title XXI.

Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the Centers for Medicare & Medicaid Services (CMS) Central Office Project Officer and the Associate Regional Administrator at the addresses shown on the award letter.

The State agrees that it will comply with all applicable Federal statutes relating to Nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

## II. GENERAL PROGRAM CONDITIONS

1. **Pre-Implementation Requirements.** All Special Terms and Conditions prefaced with an asterisk (*) contain requirements that must be approved by CMS prior to the implementation date for the demonstration. No Federal financial participation (FFP) will be provided for section 1115 program demonstration eligibles until CMS has approved these requirements. FFP will be available for such activities as project development and implementation, compliance with Special Terms and Conditions, etc. Unless otherwise specified, where the state is required to obtain CMS approval of a submission, CMS will make every effort to respond to the submission in writing within 45 days of receipt of the submission. The CMS and the State will make every effort to ensure that each submission is approved within 60 days from the date of CMS's receipt of the original submission.

2. **Definitions.** For purposes of the Special Terms and Conditions, the following definitions apply.
    a. "Implementation date" is defined as the first date on which coverage to adults is available. FFP for the Michigan Adult Benefits Waiver program is not available until the implementation date. CMS must approve in writing the state's proposed implementation date.
    b. "Adult Benefits Waiver demonstration eligibles" is defined as unisured adults ages 19-64 with net income at or below 35% of the Federal poverty level who are not otherwise eligible for Medicaid or Medicare.

3. **Adequacy of Infrastructure.** The State shall ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing limits; and reporting on financial and other issues.

4. *** Public Notice and Consultation.** The State will continue to comply, as demonstrated by previous documentation, with the public notice requirements published in the September 27, 1994 edition of the Federal Register, and the tribal consultation requirements issued via letter by CMS on July 17, 2001. In the event the state conducts additional consultation activities consistent with these requirements prior to the implementation, documentation of these activities will be provided to CMS.

5. *** Preparation of Operational Protocol.** Prior to service delivery under this demonstration, the State must prepare and CMS must approve an Operational Protocol document that represents all policies and operating procedures applicable to this demonstration. The required content of the Operational Protocol is outlined in Section IX of these Special Terms and Conditions.

6. **Extension or Phase-out Plan.** No later than 12 months prior to the expiration of the demonstration, the State must notify CMS whether it plans to request an extension of the demonstration. Requests for extensions will be due no later than one year prior to the expiration of the demonstration. If the state does not intend to request an extension, it must submit to CMS a phase-out plan no later than one year prior to the expiration of the demonstration. The phase-out plan is subject to CMS review and approval.

7. **Enrollment Limitation During the Last Six Months.** If the demonstration has not been extended, no new enrollment is permitted during the last six months of the demonstration.

8. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the demonstration, the State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent Federally funded evaluation of the demonstration program.

9. **Matching of State-funded programs.** The demonstration increases the amount and scope of publicly funded health care services in the state. The annual combined amount of state funds expended for the Adults Benefits Waiver will be maintained or increased above the SFY 2002 level during the operation of the demonstration. The maintenance of effort will be calculated over the operation of the waiver, i.e. the state must demonstrate that total state expenditures over the five years of the demonstration are equal to or exceed the total amount the state would have spent had the state made payments at the SFY 2002 expenditure level annually in absence of the demonstration. State expenditures for the Adults Benefits Waiver will count toward meeting the maintenance of effort requirement and are eligible for Federal matching

funds through this demonstration. No other current or previous state-funded program is eligible for Federal matching funds. No Federal matching for expenditures for this program will take effect until the implementation date.

10. **CMS Right to Terminate or Suspend.** The CMS may suspend or terminate this project in whole or in part at any time before the date of expiration, whenever it determines that the state has materially failed to comply with the terms of the project. The CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date. The State waives none of its rights under 42 CFR 430, Grants to States for Medical Assistance Programs, to challenge CMS's finding that the state materially failed to comply. CMS reserves the right to deny pending waiver requests or costs not otherwise matchable, or withdraw waivers or costs not otherwise matchable, at any time, if it determines that granting or continuing the waivers or costs not otherwise matchable would no longer be in the public interest. If the project is terminated or any relevant waivers or costs not otherwise matachable withdrawn, CMS will be liable for only normal close-out costs.

11. **State Right to Terminate or Suspend.** The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State must promptly notify CMS in writing of the reasons for the suspension or termination, together with the effective date. If the project is terminated or any relevant waivers suspended by the state, CMS will be liable for only normal close-out costs.

## III. GENERAL REPORTING REQUIREMENTS

1. **Quarterly Progress Reports.** Michigan will submit quarterly progress reports, which are due 60 days after the end of each quarter. The format for the report will be agreed upon by CMS and the state. These reports must include information on operational and policy issues appropriate to the State's program design. It must also include information on any issues that arise in conjunction with the premium assistance portion of the program. The State will also include a separate section to report on the impact of covering childless adults on the overall health of the community and on its progress toward agreed upon goals for reducing the rate of uninsurance and reducing the number of uninsured. The state must include a discussion of the specific content of these reports in the Operational Protocol document (see Section IX).

2. **Quarterly Enrollment Reports.** Each quarter the State will provide CMS with an enrollment report by demonstration population showing end of quarter actual and ever enrolled figures.

3. **Monitoring Calls.** CMS and the State will hold monthly monitoring calls to discuss issues associated with the implementation and operation of the demonstration.

4. **Annual Reports.** The State must submit a draft annual report documenting accomplishments, including project status, financial updates resulting from the monitoring process to include reporting of expenditures to ensure that expenditures for the HIFA amendment do not exceed available Title XXI and state match as referenced in section VIII, B3; quantitative and case study findings; policy and administrative difficulties; and progress on conducting the demonstration evaluation, including results of data collection and analysis of data to test the research hypotheses and an evaluation report on the impact that this demonstration has had on the overall health of the community, no later than six months after the end of its operational year. Within 30 days of receipt of comments from CMS, the State shall submit a final annual report. The State must include a discussion of the specific content of these reports in the Operational Protocol document (see Section IX).

5. **Final Report.** No later than 3 months after the end of the demonstration, a draft final report must be submitted to CMS for comments. CMS's comments shall be taken into consideration by the state for incorporation into the final report. CMS's document *Author's Guidelines: Grants and Contracts Final Reports* is available to the state upon request. The final report is due no later than 90 days after the receipt of CMS's comments.

## IV. LEGISLATION

1. **Changes in the Enforcement of Laws, Regulations, and Policy Statements.** All requirements of the SCHIP program expressed in laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter of which these Special Terms and Conditions are a part, will apply to the demonstration.

2. **Changes in SCHIP Law.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the SCHIP program that occur after the demonstration award date.

## V. ELIGIBILITY AND ENROLLMENT

1. **Screening for Medicaid.** Applicants for the demonstration will be screened for Medicaid eligibility. Demonstration applicants eligible for Medicaid will be enrolled in Medicaid and receive the full Medicaid benefit package.

## VI. BENEFITS

**1. Adults Not in Premium Assistance.** For adults who choose to receive coverage through direct coverage, the benefit package includes inpatient, outpatient, physician's surgical and medical services, laboratory and x-ray services, pharmacy and mental health and substance abuse. Any changes to the benefit package must be approved by CMS.

2. **Premium Assistance**. For adults who choose to receive coverage through premium assistance, CMS is approving the benefit package available through the private or employer-sponsored insurance company as the benefit package to be delivered.

3. **Residents in Institutions for Mental Diseases (IMDs).** FFP is not available for expenditures for services provided to Adults Benefits Waiver demonstration eligibles who are patients in an institution for mental diseases.

## VII. COST SHARING

1. **Adults Not in Premium Assistance.** For adults who do not choose premium assistance, the cost sharing methodology is specified by the state and is to be detailed in the Operational Protocol document.

2. **Premium Assistance**. For adults who choose to receive coverage through premium assistance, cost sharing requirements will be set by their private or employer based coverage.

## VIII. PROGRAM DESIGN

### A. Concurrent Operation

The State's Title XXI state plan, as approved, will continue to operate concurrently with this section 1115 demonstration.

### B. Maintenance of Coverage and Enrollment Standards for Children

1. The State shall not close enrollment, institute waiting lists or decrease eligibility standards with respect to the children covered under its Title XXI state plan while the demonstration is in effect.

2. The State shall, throughout the course of the demonstration, include a review of enrollment data to provide evidence that children are not denied enrollment and continue to show that it has implemented procedures to enroll and retain eligible children for Medicaid and SCHIP.

3. The State will establish a monitoring process to ensure that expenditures for the HIFA amendment do not exceed available Title XXI funding (i.e., the Title XXI allotment or reallocated funds) and the appropriate state match. The State will use Title XXI funds to cover services for the SCHIP and HIFA population in the following priority order:

    1. Children eligible under the Title XXI state plan.
    2. Adult Benefits Waiver demonstration eligibiles

If the state determines that Title XXI funding will be exhausted, available Title XXI funding will first be used to cover costs associated with the Title XXI state plan population.

The State may also, for the Adults Benefit Waiver demonstration eligibles:

- Lower the Federal poverty level used to determine eligibility, and/or
- Suspend eligibility determination and/or intake into the program, or
- Discontinue coverage

Before taking any of the above actions related to the priority system, Michigan will provide 60-day notice to CMS.

## IX. OPERATIONAL PROTOCOL

1. *** Prior Approval.** Prior to the implementation date, the State must prepare, and CMS must approve, a single Operational Protocol document representing all policies and operating procedures of the demonstration. The protocol must be submitted to CMS no later than 90 days prior to program implementation. The CMS will respond within 60 days of receipt of the protocol regarding any issues or areas that require clarification. No FFP will be provided for payments under the demonstration until CMS has approved the Operational Protocol. The State must assure and monitor compliance with the protocol. In the event that the desired implementation date is less than 90 days from the date of approval, CMS and the State agree to work in good faith to ensure that the review of the Operational Protocol is completed in a timely fashion in order to allow the State to meet its implementation timeframe.

2. **Changes to the Operational Protocol.** During the demonstration, subsequent changes to the demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures must be submitted for review by CMS. The State must submit a request to CMS for these changes no later than 90 days prior to the date of implementation of the change(s).

3. **Operational Protocol Content.** At a minimum, the protocol must address all of the following areas, plus any additional features of the demonstration referenced in these Special Terms and Conditions or the state's application for the demonstration:

    a) **Organization and Structural Administration.** A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration and coordinate with the SCHIP program, and the tasks each organizational component will perform. Include details about the organizational components responsible for eligibility, outreach, enrollment, compliance with cost sharing limitations, monitoring, evaluation, and financial management.

b) **Reporting Items.** A description of the content and frequency of each of the reporting items as listed in Section III of this document.

c) **Income Limit.** A detailed discussion of the income limit the State will use for the program.

d) **Eligibility/Enrollment.** A detailed description of the group eligible for the demonstration; and the processes for eligibility determination and annual redetermination, enrollment and disenrollment, and procedures for ensuring that all participants will be screened and enrolled in the program for which they are eligible. The State's outreach, marketing, and staff training strategy will also be detailed, including: information that will be communicated to providers, potential demonstration participants, and state outreach/education/eligibility staff; types of locations where such information will be disseminated; and the availability of bilingual materials/interpretation services and services for individuals with special needs. The State should also describe how it will review and approve marketing materials prior to their use.

e) **Implementation Schedule.** Please discuss the operational details and provide an implementation schedule.

f) **Premium Assistance.** Describe all details of the premium assistance component of the demonstration, including but not limited to, all elements described in VI.1, V.2, VII.1, VII.2, and the State's plan for assuring that premium assistance recipients are actually enrolled in private or employer-sponsored insurance.

g) **Quality.** Describe the State's overall quality assurance monitoring plan. The plan should include, at a minimum, the following: quality indicators to be employed to monitor service delivery under the demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program; quality monitoring surveys, and the monitoring and corrective action plans to be triggered by the surveys; and fraud control provisions and monitoring.

h) **Grievances and Appeals.** Provide a description of the grievance and appeal policies that will be in place in the demonstration and how the process will be monitored.

i) **Title XXI Financing.** A description of the process for monitoring allotment neutrality, and the procedures for meeting the financial requirements specified in Attachment A. The description should include the State's process for ensuring that care is not interrupted for the approved state plan population or the demonstration population should the

state expend the full amount of the available state or Federal funds during the demonstration period.

j) **Screening for Medicaid.** Describe the process that is used to screen applicants for Medicaid eligibility.

k) **Uninsured Rates.** The Operational Protocol must include the State's monitoring plan to track changes in the uninsured rate and trends in sources of insurance, including submission of progress reports discussed in Section III. Include in the description of the plan information on the sources of data and adjustments that were made to establish the base line and which will need to be made in the future. The State should plan on monitoring whether there are unintended consequences of the demonstration, such as high levels of substitution of private coverage and major decreases in employer contribution levels. This section should discuss the State's plans to measure and report on the following: changes in the uninsured rate for the population groups listed above; changes in the insured rates for the insurance coverage categories and population groups listed above; the lengths of time enrollees have been uninsured prior to enrolling in the demonstration, and the extent to which individuals appear to be dropping employer coverage in order to enroll in the demonstration.

l) **Evaluation Design.** Provide a more detailed description of the State's evaluation design, including:

- a discussion of the demonstration hypotheses that will be tested including at a minimum an evaluation of the impact of covering childless adults on the overall health of the community;
- outcome measures that will be included to the impact of the demonstration;
- what data will be utilized;
- the methods of data collection;
- how and by whom the evaluation will be conducted;
- how the effects of the demonstration will be isolated from those other initiatives occurring in the State; and
- any other information pertinent to the State's evaluative or formative research via the demonstration operations.

m) **Evaluation Report.** The State will inform CMS of the status of the state's evaluation in the quarterly, annual, and final reports using the timeframes specified in Section III, General Reporting Requirements.

## X. MONTIORING

1. ***<u>Maintenance of Effort Requirement</u>.** Prior to implementation, the State must submit a plan detailing how it will monitor and ensure that the maintenance of effort requirement contained in II.9 is met.

## ATTACHMENT A

## GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

1. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved SCHIP plan and those provided through the Michigan Adults Benefits Waiver Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal Financial Participation (FFP) only for allowable Michigan Adults Benefit Wavier Demonstration expenditures that do not exceed the State's available Title XXI funding.

2. In order to track Title XXI expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), Following routine CMS-21 reporting instructions as outlined in Section 2115 of the State Medicaid Manual. Title XXI demonstration expenditures will be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made). Once the appropriate waiver form is selected for reporting expenditures, the State will be required to identify the program code and coverage (children or adults). For this waiver and eligibility group, the program code will be MIAD and covers Adults which is found on the dropdown menu.

    a. All claims for expenditures related to the demonstration (including any cost settlements) must be made within two years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

    b. The standard SCHIP funding process will be used during the demonstration. Michigan must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the

state, and include the reconciling adjustment in the finalization of the grant award to the state.

c. The State will certify state/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other federal grant or contract, except as permitted by Federal law.

3. Michigan will be subject to a limit on the amount of Federal Title XXI funding that the State may receive on demonstration expenditures during the waiver period. Federal Title XXI funding available for demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available Title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved Title XXI separate child health program or demonstration until the next allotment becomes available.

4. Total Federal Title XXI funds for the State's SCHIP program (i.e., the approved Title XXI state plan and this demonstration) are restricted to the state's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the state plan population. Demonstration expenditures are limited to remaining funds.

5. Total expenditures for outreach and other reasonable costs to administer the Title XXI state plan and the demonstration that are applied against the state's Title XXI allotment may not exceed ten percent of total Title XXI expenditures.

6. If the State exhausts the available Title XXI Federal funds in a Federal fiscal year during the period of the demonstration, the State will continue to provide coverage to the approved Title XXI state plan separate child health program population and the Demonstration Population with state funds.

7. All Federal rules shall continue to apply during the period of the demonstration that state or Title XXI Federal funds are not available. The State is not precluded from closing enrollment or instituting a waiting list with respect to the Demonstration Population. Before closing enrollment or instituting a waiting list, the State will provide 60-day notice to CMS.